PoC accepted 5/4/06 B. Cwaner letter sent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295020	A. BUILDING ______ B. WING ______	C 05/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERRYMAN REHABILITATION CENTER	2045 SILVERADA BLVD. RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a complaint investigation initiated at your facility on January 24, and continuing until May 3, 2006 in order to consider additional evidence. The findings and conclusions of any investigation by Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint NV00010661 alleged poor quality of care due to failure to assure resident safety (substantiated), inadequate facility staffing (unsubstantiated) and resident to resident abuse (substantiated.) See F225.	F 000	**This Plan of Correction (POC) is being submitted pursuant to the applicable Federal and State Regulations. Nothing contained herein shall be construed as an admission that the facility violated any Federal or State regulations or failed to follow any applicable Standard of Care.**	5/18/06
F 225 SS=D	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225	**The Plan of Correction is cross-referenced to the appropriate deficiency. Please refer to the appropriate pages that follow each deficiency in the Plan of Correction.** RECEIVED MAY 19 2006 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Johnson
TITLE: Director of Operations
(X6) DATE: May 19, 2006

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of the medical record, facility documents, Bureau of Licensure and Certification records and interviews with staff, it was determined that the facility failed to appropriately investigate and report resident to resident abuse for 1 resident. (Resident #1) Findings include: Resident #1: The resident was bedridden due to weakness following prolonged hospitalizations and had been admitted to the facility for rehabilitation. The resident had a wound vacuum on an infected surgical wound on her leg. The resident was interviewed on 1/25/06. The resident expressed fear of an elderly female Alzheimer's Disease patient (Resident #2) who wandered into	F 225		

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F 225	Continued From page 2 her room while she was a resident in the facility. The resident said she was sleeping and felt a tugging followed by a burning sensation in the leg where the wound vacuum was positioned which awakened her and then she realized another resident was in her room. She stated that she was fearful in the facility because she did not feel there was enough staff to monitor all the residents. She was questioned as to whether the facility had done anything to alleviate her fears of the other resident and she replied that they put a guard made out of yellow cloth strips over the doorway but that, "It did not faze her." She also stated that she was afraid to nap and that, "I have been in a lot of hospitals but I have never been afraid before." The day nursing notes on 1/22/06 read, " Another resident enters room - [Patient#1] screams alerting staff to room, resident redirected." The evening nursing notes on 1/22/06 read, "Have placed stop sign across door to avert other residents from entering. Door closed at all times per resident request except when staff providing cares." Messages were left on the Director of Nurses' voice mail on two separate occasions requesting copies of the incident report and the investigation. No evidence of an investigation was ever provided. Incident reporting records in the Bureau of Licensure and Certification data base were reviewed and there was no record of an incident reported involving the Alzheimer's Disease resident who was a Medicare patient.	F 225		

F 225.483.13(c.)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS

This REQUIREMENT Is not met as evidenced by: based on review of the medical record, facility documents, Bureau of Licensure and Certification records and interviews with staff, it was determined that the facility failed to appropriately investigate and report resident to resident abuse for 1 resident (Resident #1).

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Based upon the evidence that the facility failed to appropriately investigate and report Resident-to-Resident abuse, facility Staff reviewed the effect upon Resident #1. Based upon the documentation in the Medical Record of Resident #1, "*Patient #1 screams alerting staff to room, Resident (2) redirected.*" This resulted from the Nurse's statement that "*Another Resident enters room*". Based upon these circumstances, the Staff immediately responded to Resident 1's complaint by closing Resident's door, putting up a barrier so that no wandering Residents could enter Resident 1's room without permission, and monitoring Resident 1's room very closely throughout the night to ensure Resident 1's safety and alleviate Resident 1's fear of any Resident entering Resident 1's room without permission.

Resident 1 had never notified Staff that Resident 2 touched or pulled at her tubing. It is standard practice for Nursing Staff to remove any Resident that is in a wrong room or has wandered into an area where their presence is not permitted and assist them to their room or to an area where their presence is permitted. Residents noted to wander frequently into non-permitted areas are Care-Planned regarding this *wandering* issue, and a wandering issue is not considered an abuse issue.

Corrective action will include that all reported incidents of Resident-to-Resident abuse shall be handled by the facility's designated Abuse Coordinator, who will report the incident to the appropriate agencies as required by State regulation, within the timeframe set forth by the Bureau of Licensure and Certification.

The Director of Nursing Services, who was employed at the time of this incident, is no longer employed by Berryman Rehabilitation Center and another Registered Nurse, who is an employee of Berryman Rehabilitation Center, has been appointed to the position of Director of Nursing Services.

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Based upon the evidence that the facility failed to appropriately investigate and report Resident-to-Resident abuse, all Residents have the potential to be affected by the same deficient practice.

If a Resident is reported to Staff as having been *abused* by another Resident, the Director of Social Services shall handle the complaint for immediate internal investigation. The Director of Social Services shall be responsible for reporting the

incident to the Administrator within 24 hours of occurrence. The Administrator will be responsible for ensuring that the Bureau of Licensure and Certification and the Ombudsman's Office are notified within the required timeframe.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Based upon the evidence that the facility failed to appropriately investigate and report Resident-to-Resident abuse, if a Resident is reported to Staff as having been abused by another Resident, the Director of Social Services shall handle the complaint for immediate internal investigation.

The Director of Social Services shall be responsible for reporting the incident to the Administrator within 24 hours of occurrence. The Administrator will be responsible for ensuring that the Bureau of Licensure and Certification and the Ombudsman's Office are notified within the required timeframe.

If an investigation verifies that abuse has taken place, the Administrator will take immediate corrective action.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

Based upon the evidence that the facility failed to appropriately investigate and report Resident-to-Resident abuse, the Administrator shall ensure that all reports of Resident-to-Resident abuse are investigated, and copies of incident reports and investigations are submitted to the Bureau of Licensure and Certification within the required timeframe.

Once the Administrator has received a copy of the report, the Administrator shall maintain a log of Incident Reports to ensure that the reporting records are submitted to the State Agencies, as required. The Administrator has prepared a Notice to all Department Heads emphasizing the fact that Incident Reports and Investigations of Resident-to-Resident Abuse must be investigated by the appropriate Staff and that Notice must be given to the Administrator within 24 hours that an incident has occurred. A full report of the investigation and copies of the investigation must be provided to the Administrator within five (5) days and forwarded to the Bureau of Licensing and Certification.

Dates when corrective action will be completed.

Based upon the evidence that the facility failed to appropriately investigate and report Resident-to-Resident abuse, the following corrective was taken: a Notice was sent to all Staff confirming the policy on Reporting and Investigating Resident-to-Resident Abuse on May 18, 2006.

Berryman Rehabilitation Center

Berryman Corporation

Commitment to Recovery

Memorandum

TO: ALL BERRYMAN REHABILITATION CENTER STAFF

FROM: JULIE JOHNSON, DIRECTOR OF OPERATIONS

DATE: May 18, 2006

RE: **RESIDENT ABUSE**

This Memorandum is to re-enforce and remind everyone regarding our Policy of Reporting Resident Abuse and/or Resident-to-Resident Abuse. If any Staff member notices any form of Resident Abuse, the incident should immediately be reported to your Department Head or Supervisor. The Department Head or Supervisor must then immediately contact the Director of Social Services, who will coordinate an investigation of the incident.

The Director of Social Services will report the incident to the Administrator's Office within twenty-four (24) hours of the occurrence of the incident. The Administrator will ensure that a log is maintained of all reported abuse incidents. Full reports and investigations of reported incidents must be completed and sent to the Administrator within five (5) days for action.

The Administrator will verify with the Director of Social Services that all Incident Reports and Investigations are transmitted to the State Bureau of Licensing and Certification within the required five (5) day timeframe. Any incident, in which a Resident has been injured, must be reported immediately by the Director of Social Services to the Bureau of Licensing and Certification.

2045 Silverada Boulevard • Reno, NV 89512 • Ph: 775.359.3161 • Fax: 775.331.2878